

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-028411

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3854 STATE FILE NUMBER

FILED JUL 31 1963

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (if outside corporate limits, give TOWNSHIP only) Kansas City		Length of stay in 1b 7 months	
c. FULL NAME OF (if NOT in hospital, give location) Jackson County Hospital		c. CITY OR TOWN Independence	
Inside Limits <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (if outside, give location) 405 South Spring	
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First ELIZABETH Middle LEONA Last HUNT			4. DATE OF DEATH Month 7 Day 8 Year 1963		
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 10-17-77	9. AGE (last birthday) 85	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Practical Nurse			10b. KIND OF BUSINESS OR INDUSTRY		
11a. FATHER'S NAME unknown			11b. MOTHER'S MAIDEN NAME unknown		
12a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no			12b. SOCIAL SECURITY NO. Records: Jackson County Hospital, Mo.		
13a. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis in Generalized			13b. INTERVAL BETWEEN ONSET AND DEATH Unknown		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			DUE TO (b) _____		
			DUE TO (c) _____		

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. Records: Jackson County Hospital, Mo.		17. INFORMANT Address K.C.	
18. CAUSE OF DEATH (Enter only one cause per line) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)				PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY	STATE
21. I attended the deceased from 12-20-62 to 7-8-63 and last saw her alive on 7-8-63		Death occurred at 10:15 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE J.P. McCalla, M.D. (Degree or title)		22b. ADDRESS Jackson County Hospital-Mo.		22c. DATE SIGNED 7-8-63	
23a. BURIAL, CREMATION, REMOVAL (Specify) removal	23b. DATE 7-15-63	23c. NAME OF CEMETERY OR CREMATORY Mt. Calvary		23d. LOCATION (City, town, or county) (State) Kansas City, Kans.	
24. FUNERAL DIRECTOR WEILERT FUNERAL HOMES(S) K.C., MO.		25. DATE RECD. BY LOCAL REG. 7-9-63		26. REGISTRAR'S SIGNATURE Ruth Long	

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF
P. Mc Calla
MEDICAL CERTIFICATION

ITEM NO.

DATE AMENDED

VS 300
Rev. 4/59

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed Jack T. Moore

Licensed Embalmer No. 4729

P. O. Address Trimbles No.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.